

§ 434.14 [Reserved]**Subpart C—Contracts With HMOs and PHPs: Contract Requirements****GENERAL REQUIREMENTS****§ 434.20 Basic rules.**

(a) *Entities eligible for risk contracts for services specified in § 434.21.* A Medicaid agency may enter into a risk contract for the scope of services specified in § 434.21, only with an entity that—

(1) Is a Federally qualified HMO, including a provisional status Federally qualified HMO;

(2) Meets the State plan's definition of an HMO, as specified in paragraph (c) of this section;

(3) Is one of several entities identified in section 1903(m)(2)(B) (i), (ii) and (iii) of the Act, and considered as PHPs;

(4) Is one of certain Community, Migrant and Appalachian Health Centers identified in section 1903(m)(2)(G) of the Act. Unless they qualify for a total exemption under section 1903(m)(2)(B), these entities are subject to the regulations governing HMOs under this part, with the exception of the requirements of section 1903(m)(2)(A) (i) and (ii) of the Act; or

(5) Is an HIO that arranges for services and becomes operational before January 1, 1986.

(b) *Entities eligible for other kinds of contracts.* A Medicaid agency may enter into a nonrisk contract, or a risk contract for a scope of services other than the scope specified in § 434.21(b), with any of the entities identified in paragraph (a) of this section, or with any other PHP.

(c) *State plan definition of HMO.* If the plan provides for risk contracts with entities that are not Federally qualified HMOs, for the services specified in § 434.21(b), the plan must include a State definition of an HMO. Under the definition, the HMO must meet at least the following requirements:

(1) Be organized primarily for the purpose of providing health care services.

(2) Make the services it provides to its Medicaid enrollees as accessible to them (in terms of timeliness, amount, duration, and scope) as those services

are to nonenrolled Medicaid recipients within the area served by the HMO.

(3) Make provision, satisfactory to the Medicaid agency, against the risk of insolvency, and assure that Medicaid enrollees will not be liable for the HMO's debts if it does become insolvent.

(d) *Services that may be covered.* A contract with an HMO or a PHP may cover services to enrolled recipients that are not provided under the plan to non-enrolled recipients as permitted under § 440.250(g) of this chapter.

(e) *Requirements for all contracts.* For all contracts with HMOs or PHPs—

(1) The contract must meet the requirements of § 434.6;

(2) The Medicaid agency must carry out the responsibilities specified in subpart E of this part; and

(3) The contract must provide that any cost-sharing requirements imposed for services furnished to recipients are in accordance with §§ 447.50 through 447.58 of this chapter.

[48 FR 54020, Nov. 30, 1983, as amended at 55 FR 23744, June 12, 1990; 55 FR 51295, Dec. 13, 1990; 56 FR 10515, Mar. 13, 1991]

ADDITIONAL REQUIREMENTS**§ 434.21 Contracts that must meet additional requirements.**

(a) Unless otherwise indicated, the additional requirements set forth in §§ 434.23 through 434.38 must be met in all types of contracts with HMOs and PHPs:

(1) Nonrisk contracts;

(2) Risk comprehensive contracts; and

(3) Other risk contracts.

(b) Risk comprehensive contracts are risk contracts for furnishing or arranging for comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services or groups of services:

(1) Outpatient hospital services and rural health clinic services.

(2) Other laboratory and X-ray services.

(3) Skilled nursing facility (SNF) services, early and periodic screening, diagnosis and treatment (EPSDT), and family planning.

(4) Physicians' services.

(5) Home health services.

(c) Other risk contracts are risk contracts for a scope of services other than those specified in paragraph (b) of this section.

[48 FR 54020, Nov. 30, 1983, as amended at 55 FR 51295, Dec. 13, 1990]

§ 434.22 Application of sanctions to risk comprehensive contracts.

A risk comprehensive contract must provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by HCFA under § 434.67(e).

[59 FR 36084, July 15, 1994]

§ 434.23 Capitation fees.

The contract must specify—

(a) The actuarial basis for computation of the capitation fees; and

(b) That the capitation fees and any other payments provided for in the contract do not exceed the payment limits set forth in §§ 447.361 and 447.362 of this chapter.

§ 434.25 Coverage and enrollment.

(a) The contract must provide that—

(1) There will be an open enrollment period during which the HMO or PHP will accept individuals who are eligible to be covered under the contract—

(i) In the order in which they apply;

(ii) Without restriction, unless authorized by the Regional Administrator; and

(iii) Up to the limits set under the contract; and

(2) Enrollment is voluntary.

(b) Risk comprehensive contracts with HMOs must also provide that the HMO will not discriminate, against individuals eligible to be covered under contract, on the basis of health status or need for health services.

§ 434.26 Composition of enrollment.

(a) *Basic rule.* Except as provided in paragraph (b) of this section, the contract must provide that Medicare beneficiaries and Medicaid recipients constitute less than 75 percent of the total enrollment of the HMO or PHP.

(b) *Exceptions—*(1) *Waiver for new HMOs with risk comprehensive contracts.* The requirement of paragraph (a) of

this section may be waived for up to three years from the date the Regional Administrator determines the entity to be an HMO (as provided in § 434.71) if the HMO submits annual reports demonstrating to the Regional Administrator's satisfaction, that it is making continuous efforts and progress toward achieving compliance with paragraph (a) of this section.

(2) *Waiver for public HMOs with risk comprehensive contracts.* The Regional Administrator may approve waiver or modification of the requirement of paragraph (a) of this section, for an HMO that is owned or operated by a State, county or municipal health department or hospital, if—

(i) There are special circumstances that justify modification or waiver; and

(ii) The HMO has made and continues to make reasonable efforts to enroll individuals who are not eligible for Medicare or Medicaid.

(3) *Waiver for certain nonprofit HMOs with risk comprehensive contracts.* The Regional Administrator may approve waiver or modification of the requirement of paragraph (a) of this section, for a nonprofit HMO which has a minimum of 25,000 members, is and has been federally qualified for a period of at least 4 years, provides basic health services through members of its staff, is located in an area designated as medically underserved under section 1302(7) of the Public Health Service Act, and has previously received a waiver under section 1115 of the Act of the requirement described in paragraph (a) of this section, if—

(i) There are special circumstances that justify modification or waiver; and

(ii) The HMO has made and continues to make reasonable efforts to enroll individuals who are not eligible for Medicare or Medicaid.

(4) *Waiver for PHPs and for HMOs that have contracts other than risk comprehensive.* The Medicaid agency may waive the requirement of paragraph (a) of this section if the PHP or HMO requests waiver and shows good cause.

(5) *Special exemption.* (i) Community, Migrant and Appalachian Health Centers identified in section 1903(m)(2)(G)